DRAFT

Report of the Certificate of Need Task Force

Presented to the
Maryland Health Care Commission

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I. Introduction

Purpose of the CON Task Force

The goal of the CON Task Force is to enhance the credibility and integrity of the Certificate of Need program in a dynamic and evolving health care system, by conducting a stakeholder driven review, using a combination of a broadly representative Task Force and public comment process, to gain insight and make recommendations to enhance and improve the program. The objectives of the CON Task Force are to:

- Review and recommend modifications in the scope of services and facilities regulated under the Certificate of Need program.
- Review and recommend enhancements in the Certificate of Need application review process.
- Review and recommend enhancements in the monitoring of Certificate of Need projects under development.

CON Task Force Composition

The CON Task Force was established by Stephen J. Salamon, Chairman of the Maryland Health Care Commission. The 24-member CON Task Force is chaired by Commissioner Robert E. Nicolay. Commissioners Robert E. Moffit, Ph.D. and Larry Ginsburg also serve on the Task Force. Members of the Task Force include representatives of the Maryland Hospital Association, Med-Chi, CareFirst BlueCross BlueShield, Health Facilities Association of Maryland, LifeSpan, Hospice Network of Maryland, Maryland Ambulatory Surgical Association, and other interested organizations (Appendix A provides a list of CON Task Force members).

II. Summary of CON Task Force Recommendations and Type of Change Required: Scope of Coverage, State Health Plan, and CON Review Process

Recommendation	Statutory Change	Regulatory Change	Administrative Change
Scope of CON Coverage			
• Increase the capital expenditure review threshold from $1.25 to $10.0 million	§19-120	COMAR 10.24.01	
• Remove home health agency from the definition of "health care facility"	§19-114(d); §19-120(j)(2)(iii)3	COMAR 10.24.01; COMAR 10.24.08	
• Remove requirement for public informational hearing for hospital closures in jurisdictions with more than two hospitals; remove requirement to obtain an exemption from CON review for hospital closures in jurisdictions with fewer than three hospitals	§19-120(l)(1)(ii) §19-120(l)(2)(i)	COMAR 10.24.01	
• Expand the existing business office equipment exemption to include health information technology/medical information systems [§19-120(k)(5)(iii)]		COMAR 10.24.01	
• Develop streamlined ("Fast Track") CON review process for hospital renovation and new construction projects with no new services or beds that do not require a partial rate review; issue Staff Report within 60 days and Commission Decision within 90 days or project is deemed approved.	§19-120(k)(5)(viii)	COMAR 10.24.01	
• Revise Determination of Non-Coverage requirements for hospitals taking the "pledge" not to increase rates to deem the request approved if not acted upon by the Commission within 60 days	§19-120(k)(5)(viii)	COMAR 10.24.01	

Recommendation	Statutory Change	Regulatory Change	Administrative Change
State Health Plan			
• Conduct comprehensive review and update of the State Health Plan:			
o Prioritize the update of the Acute Inpatient Services and Ambulatory Surgical Services chapters of the State Health Plan		COMAR 10.24.10; 10.24.11	
o Add policies to the Acute Inpatient Services chapter of the State Health Plan permitting shell space.		COMAR 10.24.10	
o For all chapters of the State Health Plan streamline documentation requirements; eliminate obsolete and duplicative standards; and identify those types of projects eligible for review based on a limited set of standards.		COMAR 10.24.07-12; 10.24.14-15; 10.24.17-18	
• Use the 71.4% occupancy rate assumption implied by the Office of Health Care Quality's statutory 140% licensing rule as the occupancy rate standard in acute care bed need projections for all services.		COMAR 10.24.10	
Certificate of Need Review Process			
• Modify the completeness review and project review process by requiring two conferences as a standard feature of the review of any CON application: (1) an Application Review Conference (ARC) between staff and the applicant, which can be a face-to-face or by telephone conference, scheduled within the approximate time frame at which the staff currently issues completeness questions; and, a Project Status Conference (PSC) between any appointed Reviewer, the staff, the applicant, and any interested parties, in person or by telephone.		COMAR 10.24.01	
• Modify the review process by allowing for changes in a project, addressed in the PSC, that bring it in closer conformance with the State Health Plan, based on staff or the		COMAR 10.24.01	

Recommendation	Statutory Change	Regulatory Change	Administrative Change
Reviewer's analysis, without penalizing such changes by adding more process or time to the review. • Develop automated CON application form; require PDF of CON application document; develop standard form for filing requests for Determinations of Non-Coverage; provide website access to CON filings.		COMAR 10.24.01	Prepare automated application forms for CON review and Determinations of Non-Coverage; design CON website; revise CON database.

III. Recommendations of the CON Task Force

Principles to Guide the CON Program

Maryland's Certificate of Need program should:

- respond to its residents' needs for health care services, including hospital, long term care, ambulatory surgery, and specialized services,
- promote the quality and safety of these services,
- promote improved access to these services by addressing the needs of underserved populations and the racial disparities which presently exist, and
- promote the affordability of health care available to Maryland residents.

Certificate of Need should be applied only in situations where competition through normal market forces is likely to result in:

- significantly higher or unnecessary costs to the system,
- decreased access to care by vulnerable populations or less populous regions of the state, or
- a diminution of the quality or safety of patient care.

The Certificate of Need program should be:

- procedurally clear, consistent, and timely;
- flexible enough to accommodate unique situations, whether of provider mission, geography and demographics, or technological advances; and
- specific to Maryland's unique policy and regulatory framework.

The State Health Plan standards, review criteria, and associated data used to conduct Certificate of Need reviews should be kept current, and regularly updated.

Traditionally, the CON process in Maryland has been a natural component of state health planning, a process for assuring access to high quality health care services and controlling health care costs. This planning approach is based on the observation that competition and market forces do not always produce the most appropriate allocation of health care resources or the best outcomes. The CON process encompasses a fundamental review of need and resource allocation, but also brings standards to bear at the time of review that are intended to improve the quality of care and patient safety.

CON is applied to a range of different situations with somewhat different rationales:

- **Major capital investments**. Where large capital investments are involved, market forces may not appropriately match investments to community and regional needs. Because any given area has only one or a limited number of hospitals and because barriers to new competitors are high, the market for hospital services is unusual. Rather than leading to innovation and lower costs, unregulated competition may be wasteful. This use of CON

addresses escalating health care costs by limiting investment when need cannot be shown. This use of CON also addresses access to quality services by regulating the location of new facilities.

- **Services with a volume/outcome association**. When there is a well-established link between volume of specialized services and outcomes CON can be used to assure access to high quality services by attaching service volume requirements to a certificate. This process also involves an assessment of need. In the long term, surrogate quality measures like volume should be replaced by specific measures of quality and outcomes, and the up-front regulation through CON should be replaced by a meaningful, on-going licensure process that considers quantitative measures of quality and outcomes.

- **Other services**. In the case of other services, the capital investment is smaller and there is less evidence of a volume/outcome association. In some cases, such as ambulatory surgery facilities, there are specific design issues that affect safety that may warrant review. But ultimately for many of these other services, competition coupled with a rigorous recurrent licensure process may be a better strategy to assure high quality and good outcomes.

Because CON involves a careful assessment of need, it is also well suited to promote improved access to underserved populations.

The strengths of the CON process in addressing cost, quality, and access are substantial, but are accompanied by negative effects on competition. CON is inherently anti-competitive, limiting new entrants, limiting new investments, limiting the introduction of some services in response to emerging needs or consumer demand, and protecting current providers. Indeed, the CON statute appropriately requires an assessment of the impact of a proposed certificate on other providers and grants those providers special status in the review process. However, the ultimate measure of effective CON must be the impact on the interests of the citizens of Maryland, not its impact on current providers. CON should only protect current providers from potential competitors when there are strong and convincing public interest arguments.

Scope of CON Coverage

Background and Issues

- ***Capital Expenditure Review Threshold***

Under Maryland health planning law, a CON is required before a new health care facility is built, developed, or established; an existing health care facility is moved to another site, subject to some limitations; the bed capacity is changed, subject to several limitations; the type or scope of any health care service offered by a health care facility is changed. In addition, any health care facility that makes

a capital expenditure that exceeds the threshold for capital expenditures is required to obtain a CON. The current capital expenditure review threshold is $1,650.000.[1]

The capital expenditure threshold functions as a trigger for CON review in conjunction with the other requirements of the law. For example, if an action would otherwise require a CON, then that requirement would apply regardless of whether the capital expenditure was below the review threshold. In the case of acute care hospitals, the capital expenditure threshold functions as a trigger in conjunction with provisions in the statute that give hospitals the ability to undertake certain types of projects above the threshold without the requirement for a CON, provided the project does not require, over the entire period or schedule of debt service associated with the project, a total cumulative increase in patient charges or hospital rates of more than $1,500,000 for the capital costs. The ability to avoid CON review for over-threshold capital expenditures by "taking the pledge" not to increase rates applies only to hospitals.

Because of differences in the scope of CON programs nationally, comparative data on capital expenditure thresholds is limited. Based on available data from the American Health Planning Association, Maryland's health facility capital expenditure review thresholds have generally been near the national norm over the last decade. In 1993, the Maryland threshold ($1.25 million) was substantially higher than the national median and mode, both $1.0 million. In 1996, the Maryland threshold was roughly equal to the national median and still higher than the mode. Maryland is one of six states with CON programs that index their capital expenditure thresholds.[2] By 2004, the Maryland threshold ($1.6 million), though indexed, was lower than both the national median ($2.0) and mode ($2.0 million) threshold values in comparable CON states.

The Task Force received comments from 11 organizations supporting an increase in the capital expenditure threshold for CON review. The comments recommended an increase in the capital expenditure threshold ranging from $5.0 to $10.0 million. There was also a recommendation to base the threshold on a percentage of revenue rather than have a fixed dollar threshold. In suggesting that the capital expenditure threshold be increased, most commenters believed that this would decrease the number of projects requiring CON review.

- ***Covered Facilities and Services***

Under Health-General Article §19-120, a CON is required before a new health care facility (service) is built, developed, or established:

  - Hospitals
  - Nursing homes

[1] The former Health Resources Planning Commission's original enabling statute (Ch. 108, Acts of 1982) set the capital review threshold at $600,000; this was amended in 1988 (Chs. 688 and 767, Acts of 1988) to $1,250,000. Beginning in 1995, the capital expenditure threshold was indexed annually to consider inflation. In a revision to CON procedural regulations effective November 6, 1995, the definition of "threshold for capital expenditures" was expanded to add the phrase "for 1995, after that to be adjusted annually by the Commission according to the Consumer Price Index-Urban (CPI-U) for the Baltimore Metropolitan Area published by the U.S. Department of Labor, and rounded off to the nearest $50,000."

Except for Maryland, which does not regulate major medical equipment, states that index their health facility capital expenditure review thresholds also index their medical equipment review thresholds.

- Ambulatory surgical facilities (two or more operating rooms)
- Residential treatment centers
- Intermediate care facilities
- Home health and hospice agencies
- Specialized health services (OHS, organ transplant surgery, NICU, and burn care)

In addition to covering the development of certain new health facilities and services, the Maryland CON statute also has provisions applying to closures. Under current law, there is a requirement for a public informational hearing for hospital closures in jurisdictions with more than two hospitals and the requirement for an exemption from CON review for hospital closures in jurisdictions with fewer than three hospitals.

While Maryland law provides that a CON is not required before a health care facility makes a capital expenditure for business or office equipment that is not related to patient care, the Task Force received several comments noting the need to clarify the application of this provision to health information system technology.

The HSCRC plays a pivotal role in the Commission's oversight of acute care hospitals under the Certificate of Need program. For all acute care hospital reviews conducted under the Certificate of Need program, the Commission consults with HSCRC concerning the financial feasibility of the proposed project. Under a 1988 change to the health planning law, certain hospital capital projects do not require CON review if the hospital assures HSCRC that the debt service of the project will not raise rates more than $1.5 million during the entire period of debt service related to the project (the "Pledge").

Task Force Recommendations

The Task Force discussed elimination or modification of the scope of CON coverage of hospice, obstetric, open heart surgery, organ transplant, and neonatal intensive care unit (NICU) services. No change in the scope of regulation for these services was recommended by the Task Force.

1. The Task Force recommends an increase in the statutory capital expenditure review threshold from $1.25 to $10.0 million (maintain the annual adjustment for inflation).

2. The Task Force recommends that the requirement for CON be eliminated for the following:

    - Remove requirement for public informational hearing for hospital closures in jurisdictions with more than two hospitals; remove requirement to obtain an exemption from CON review for hospital closures in jurisdictions with fewer than three hospitals

    - Expand the existing business office equipment exemption to include health information technology/medical information systems [§19-120(k)(5)(iii)]

- Remove home health agency from the definition of "health care facility"

3. The Task Force recommends the development of a streamlined ("Fast Track") CON review process for hospital renovation and new construction projects with no new services or beds that do not require a partial rate review; issue Staff Report within 60 days and Commission Decision within 90 days or project is deemed approved.

4. For hospitals taking the "pledge" not to increase rates, the Task Force recommends revising Determination of Non-Coverage requirements to deem the request approved if not acted upon by the Commission within 60 days

State Health Plan

Background and Issues

Under Health-General Article §19-118, the Commission is required at least every five years to adopt a State Health Plan. The plan shall include: the methodologies, standards, and criteria for certificate of need review; and, priority for conversion of acute capacity to alternative uses where appropriate. The current State Health Plan is organized in 10 chapters:

COMAR 10.24.07	Overview, Psychiatric Services
COMAR 10.24.08	Long Term Care Services
COMAR 10.24.09	Specialized Health Care Services-Acute Inpatient Rehabilitation Services
COMAR 10.24.10	Acute Inpatient Services
COMAR 10.24.11	Ambulatory Surgical Services
COMAR 10.24.12	Acute Hospital Inpatient Obstetric Services
COMAR 10.24.14	Alcoholism and Drug Abuse Intermediate Care Facility Treatment Services
COMAR 10.24.15	Specialized Health Care Services-Organ Transplant Services
COMAR 10.24.17	Specialized Health Care Services-Cardiac Surgery and Percutaneous Coronary Intervention (PCI) Services
COMAR 10.24.18	Specialized Health Care Services-Neonatal Intensive Care Services

Each chapter of the State Health Plan is incorporated by reference in the Code of Maryland Regulations (COMAR).

The plan development process used by the Commission has typically involved advisory groups and extensive public comment and review prior to formal adoption of plan chapter. In the most recent update of the cardiac services chapter of the State Health Plan, for example, the Commission considered the findings and recommendations of an Advisory Committee on Outcome Assessment in Cardiovascular Care and its subcommittees. To assist in the recent update of the State Health Plan acute care bed need methodology and bed need forecasts for medical-surgical-gynecological-addictions (MSGA) and pediatric services, the Commission formed an Acute Care Hospital Work Group. The planning process used by the Commission also involves extensive data collection and analysis and the preparation of issue and statistical briefs to track key trends in health services utilization. Data sets used to support preparation of the

State Health Plan include the HSCRC data on inpatient, ambulatory surgery, and emergency department use as well as the Commission's Maryland Freestanding Ambulatory Surgery Survey, Maryland Hospice Survey, and the Maryland Long Term Care Survey.

The Task Force received a number of comments regarding the importance of an updated State Health Plan in guiding the CON review process. A large proportion of these comments specifically addressed the need to update the acute care services chapter of the State Health Plan. Although the Commission historically reviewed few hospital CON proposals, this pattern changed a few years ago as hospital utilization increased and financing became more favorable. CON proposals from acute care hospitals now account for the largest volume of the Commission's CON workload. Because of recent interest in expanding surgical capacity, the Task Force also discussed the need to review and update the ambulatory surgical services chapter of the State Health Plan as a priority.

The Task Force also received comments regarding the average annual occupancy rate scale currently used in the State Health Plan to forecast the need for medical/surgical/gynecology/addictions (MSGA) beds, including the recommendation to use a single average annual occupancy rate standard of 71.4%. This latter standard (often referred to as the "140% rule" – 100/140 = 71.4%) is used by the Department of Health and Mental Hygiene to establish the total number of licensed acute care beds in hospitals by applying it to historically reported total acute care average daily census. Maryland's hospital licensure law was amended, effective in 2000, to peg maximum licensed acute care bed capacity to the average daily census of acute care patients reported by hospitals. On July 1 of each year, hospital licenses are revised to reflect that the hospital is licensed (and, thus, may legally operate) a total number of acute care beds equal to 140% of the average daily census of acute care patients reported by that hospital for the twelve month period ending on March 31 of that same year The CON law was also amended to allow hospitals to construct acute care bed capacity equal to their current licensed capacity without reference to any need standards of the State Health Plan. This law had the effect of eliminating over 2,700 beds from hospital licenses when it went into effect. Currently, Maryland hospitals report that, in the aggregate, they have physical capacity for 967 more acute care beds than are licensed. Twelve of the state's 47 hospitals (26%) report having less physical capacity for acute care beds than is currently licensed.

MHCC projects the need for MSGA beds and uses this bed need projection in evaluating proposals to establish new acute care hospitals, replace existing hospitals, or expand the MSGA bed capacity of existing hospitals. It uses an occupancy rate scale in projecting the need for beds based on:

- An assumption that as the average daily census of MSGA patients increases, hospitals can manage patient census at a higher level of average annual occupancy; and

- A policy that a hospital should operate at the highest level of average annual occupancy, given its level of patient census, which allows it to accommodate emergent and urgent needs for admission immediately, with only rare exceptions, and to accommodate less urgent and more elective needs for admission within a reasonable period of time.

The current MSGA average annual bed occupancy rate scale was adopted in 2004 and is lower than the scale previously used in the State Health Plan to account for the higher level of bed turnover which occurs as average length of stay declines. The current scale, the previous scale (in parentheses), and the distribution of Maryland's 47 acute care hospitals on this scale is provided below:

Projected Average Daily Census	Average Annual Occupancy Rate	Number of Hospitals Falling within the Standard
0-49 patients	70% (75%)	8
50-99 patients	75% (80%)	11
100-299 (499) patients	80% (85%)	26
300+ (500+) patients	83% (87%)	2
	79% weighted average	47

Use of a 71.4% average annual occupancy rate scale for all Maryland acute care hospitals in bed need projection would result in large differences in the potential number of additional MSGA beds that could be approved. MHCC's current MSGA bed need forecast, when compared with currently designated licensed MSGA beds, identifies a potential for 398 to 777 additional beds needed by 2010. If this bed need projection had been developed using an identical forecast of MSGA patient days in 2010 but with a 71.4% occupancy standard applied to each jurisdiction, the identified potential for additional beds would be 873 to 1,775. With hospital construction costs of $750,000 to $1 million per bed, this would represent the potential for nearly $1 billion in additional capital spending for bed capacity.

Task Force Recommendations

1. Because of its importance in guiding the CON review process, the Task Force recommends that the Commission undertake a comprehensive revision of the State Health Plan. The update and revision of the State Health Plan should involve technical advisory groups to obtain expertise on factors influencing the availability, access, cost, and quality of services. The review of each chapter of the State Health Plan should

    - Eliminate obsolete and duplicative CON review standards;
    - Streamline documentation requirements; and
    - Identify those types of projects eligible for review based on a limited set of standards.

2. In updating the State Health Plan, priority should be given to revision of the Acute Inpatient Services and Ambulatory Surgical Services chapters:

    Acute Inpatient Services (COMAR 10.24.10)

    The revision of the Acute Inpatient Services chapter of the State Health Plan should eliminate obsolete and redundant standards, including: .06A(2) Utilization Review Control Programs; .06A(3) Travel Time; .06A(4) Information Regarding Charges;

.06A(5) Charity Care Policy; .06A(6) Compliance with Quality Standards; .06A(7) Transfer and Referral Agreements; .06A(8) Outpatient Services; .06A(9) Interpreters; .06A(10) In-Service Education; .06A(11) Overnight Accommodations; .06A(12)Required Social Services; .06A(19) Minimum Size for Pediatric Unit; .06A(20) Admission to Non-Pediatric Beds; .06A(21) Required Services When Providing Critical Care; .06A(22)Average Length of Stay for Critical Care Units; .06A(23) Waiver of Standards for Proposals Responding to the Needs of AIDS Patients; .06B(1) Compliance with System Standards; .06B(2) Duplication of Services and Adverse Impact; .06B(4) Burden of Proof Regarding Need; .06B(5)Discussion with Other Providers; .06B(9) Maximum Square Footage; .06C(2) Compliance with System Standards; .06C(3) Conditions for Approval; and, .06C(5) Maximum Square Footage-Renovations. The revision should add policies to the Acute Inpatient Services chapter of the State Health Plan permitting shell space.

Ambulatory Surgical Services (COMAR 10.24.11)

The revision of the Ambulatory Surgical Services chapter should consider the implications of defining the exemption from CON regulation for establishment of single operating room ambulatory surgical facilities as an exemption for a single room for the provision of invasive procedures within a practitioners office, whether the room is a sterile operating room or a non-sterile "procedure room." This will require consideration of definitions of the terms "operating room" and "procedure room" and revised and expanded definitions of "full" and "optimal capacity" for different categories of surgical room.

3. The 71.4% Average Annual Occupancy Rate Assumption Implied by the 140% Rule should be Used as the Occupancy Rate Standard in Acute Care Bed Need Projections.

   Because the statute provides that hospital's may be licensed for a total number of beds equal to 140 percent of their average daily census, which is equivalent to an annual overall occupancy rate of 71.4 percent, the Task Force believes that the Commission's bed need projections should be based on the same occupancy level assumption for all services.

CON Review Process

Background and Issues

The current procedural regulations that govern the CON process (COMAR 10.24.01.08C Completeness Review and Docketing) provide that:

(1) Staff has 10 days in which to conduct a "completeness" review;

(2) Applicants have 10 days in which to respond to staff's questions generated during the completeness review;

(3) Completed applications are to be docketed – applications lacking necessary information can be dismissed and returned;

(4) 10 day extensions to supply required information can be approved by staff (only with consent of all applicants in comparative reviews);

(5) Staff may request additional supplementary information at any time after docketing.

Applicants frequently make changes to certificate of need applications after docketing, sometimes triggering a "re-docketing" of the application pursuant to COMAR 10.24.01.08E.

Only "modifications" require re-docketing – changes that do not involve certificate of need regulated facilities or services do not constitute "modifications" requiring re-docketing. Applicants may:

(1) Modify applications at any time up until 45 days after docketing;

(2) In comparative reviews, modify an application only with consent of all the applicants after the 45th day; and

(3) In non-comparative reviews, (a) reduce costs, (b) reduce annual projected revenue, (c) reduce beds and services or (d) make changes to respond to the changes in the State Health Plan at any time (only with consent of other applicants in comparative reviews).

Re-docketing permits public notice of and response to the changed application. Consequently re-docketing also extends the Commission's time to approve or deny an application.

The Task Force received a number of comments regarding various components of the CON review process, including completeness review, requests for additional information, and re-docketing rules. Comments received regarding completeness review fall into four general categories, including what specific information is required for the Commission to find an application complete in order to initiate the review, the length of time that should be permitted for the Commission to conduct completeness review, the length of time that applicants should be permitted to respond to completeness review, and the role of interested parties in completeness review. Comments were also received concerning the delay caused by the requirement for re-docketing for an applicant that makes certain changes to an application. Taken together these comments raise issues about the structure and timeliness of the project review process.

Task Force Recommendations

The Task Force reviewed the regulations governing designation of interested parties in CON reviews and recommended no changes. The Task Force also considered the advantages and disadvantages of eliminating the review schedule and recommended that the schedule by retained. In reviewing other CON review process issues, the Task Force made the following recommendations:

1. The Task Force recommends that the review process be restructured to require two conferences as a standard feature of the review of any CON application:

   Application Review Conference

   - The format of this conference should be a walk-through of the application and its appendices at which the staff will provide the applicant with its views on the completeness of each question or information requirement outlined in the application;
   - The conference will serve to formulate the written completeness review questions with input from both staff and the applicant; and
   - Because of the conference, the completeness questions, prepared by staff and given to the applicant within a reasonably short period after the ARC, will be fewer and limited to more substantive issues which could not be fully addressed at the conference or which require development of information or analyses by the applicant; and better understood by the applicant because of the applicant's participation in framing the questions at the ARC.

   Project Status Conference

   - A Project Status Conference will be held to address those standards and review criteria which present a problem for approval of the project. Prior to this meeting, the Reviewer or staff will send a memorandum to the applicant and interested parties outlining the areas of concern so that the applicant can have appropriate persons attend the PSC.
   - The PSC will be structured to allow the applicant and interested parties to ask questions about the status of the project and provide comment regarding the identified issues;
   - A written summary of the PSC will be prepared for the record, along with a statement of applicant revisions to the Summary, if desired by the applicant;
   - Following the PSC, the applicant will have an appropriate period of time to make changes, if desired, to the project, which cure the problems or deficiencies identified at the PSC, without the requirement for re-docketing. Each interested party will have a 10 day period in which to file comments on changes to the project.

This recommendation is intended to allow for more expeditious processing of projects that contain a number of distinct elements, some of which are in conformance with MHCC plans and policy and should be allowed to go forward quickly and other elements that do not conform, but, if modified or eliminated, make approval of the entire project feasible. Given the multi-faceted nature of many projects and the fact that such projects can be modified in ways that improve compatibility with the State Health Plan and CON law, without compromising feasibility, this recommendation aims to make the project review process more collaborative.

2. The Task Force recommends modifying the review process by allowing for changes in a project, addressed in the Project Status Conference, that bring it in closer conformance with the State Health Plan, based on staff or the Reviewer's analysis, without penalizing such changes by adding more process or time to the review.

3. The Task Force recommends developing an automated CON application form; requiring PDF files of CON application documents; developing a standard form for filing requests for Determinations of Non-Coverage; and, providing website access to CON filings.

Appendix A

Maryland Health Care Commission
Certificate of Need Task Force[3]

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